South Carolina Department of Health and Human Services
REQUEST FOR VERIFICATION OF VETERANS INFORMATION

From: (Name & Address of DHHS Office)	Name of Veteran:	
	VA Claim Number:	
	Veteran's Social Security Number:	
	Primary Individual:	
To:	Household Number:	
Veterans Administration Regional Office	Eligibility Worker:	
6437 Garners Ferry Road	Phone:	Fax:
Columbia, SC 29209	Date:	

I HEREBY AUTHORIZE THE VETERANS ADMINISTRATION TO FURNISH THE FOLLOWING INFORMATION TO THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

SIGNATURE OF VETERAN/RESPONSIBLE PERSON	RELATIONSHIP TO VETERAN	DATE

Name(s) of Applicant(s):		
Relationship to Veteran:		
1. Type of Payment		
2. Is payment based upon need?	☐ Yes ☐ No	☐ Yes ☐ No
3. Specify frequency if other than monthly		
4. Gross Payment Amount		
a. A & A Amount included		
b. UME Amount included		
c. DIC Amount included		
5. Overpayment Amount Withheld		
a. Period of Recovery		
6. Gross Retroactive Payment Amount		
a. A & A Amount included		
b. UME Amount included		
c. DIC Amount included		
d. Date Paid		

SIGNATURE OF VA OFFICIAL	TELEPHONE NUMBER	FAX NUMBER	DATE